Minutes & Action Items: Public Inebriate Summer Study meeting 7/19/2007

Present: Barbara Cimaglio, Peter Lee, Peter Albert, John Pandiani, Peg Andrews, Mark Schroeter, Jay Simons, Dick Powell, Phil Fernandez, Russell Frank, Mary Moulton, Tom Hanley, Cathy Rousse, Jennifer Carbee, Kathy Duhamel, Jon Coffin, John Swartz, John Perry, Susan Onderwyzer, Paul White, Sheryl Beckman, Marian Greenberg, Lucie Garand, Beth Tanzman, Connie Schütz

Minutes

Background presentations:

John Perry, Dept of Corrections: One person was housed at CCRF as incapacitated 18 times in March, with a further 7 nights as a detainee for trespassing. He spent 32 nights at Chittenden during the course of 6 months. This person is homeless, living in a garage. His neighbors know this – calls only begin to come in when he has to move out of the garage temporarily because it is shared with a family of raccoons. CCRF processes 40% of men and 30% of women incarcerated in Vermont. It also serves as shelter for 50% of incapacitated persons. The other high-volume correctional facility for inebriates is Marble Valley in Rutland. With the recent shift of contract to Serenity House, which offers service at all levels from detox to residential to transitional housing, it is hoped that the situation in Rutland will improve.

Persons with repeat public inebriate admissions are more likely to have a prior criminal record. During the last 16 years, 75% of people were only admitted as incapacitated once. The remaining 25% of inebriates make up 45% of the lodgings for inebriation.

The Act One diversion rate currently is about 50%. In the past, for a period of time, a CCRF staff person was stationed at Act One. During that period of time, the diversion rate went up to 70%, although the absolute number of incapacitated persons rose due to an increase in inebriates.

Beth Tanzman, Dept of Mental Health: Beth has been visiting hospital ED's in order to gather information about hospital management concerns regarding co-occurring issues. More than specifics, she offered contextual assessments. Nine of fourteen hospitals have been visited thus far. There is wide variability in what hospitals offer and how they think of themselves. Some hospitals would prefer to deal with what they see as 'real emergencies,' rather than substance abuse and mental health issues. All of the hospitals visited report increased acuity and behavioral interruptions from patients. Concerns exist about whether other patients seeking care feel safe in the environment. Some of the patients coming in for help are more impaired than the ED is set up to deal with. Mental health dispositions are difficult, as it takes a great deal of time to find placements. Substance abuse dispositions are difficult because often there is no place for people to go. They end up being discharged when their level of inebriation has dropped sufficiently. This creates a dissonance for clinicians as all potential for follow-up is lost at that point.

Emergency departments report regularly offering medical admissions to stabilize substance abusers, although they feel it is outside of the scope of their practice and knowledge. They find it difficult even to get a consult. 'Drug-seeking' individuals have increased considerably in recent years. Some suggest a good pain-management clinic might alleviate this issue.

John Pandiani, Dept. of Mental Health: a report was presented of the number of inebriate contacts with Vermont State Police and other participating police departments. Most of the data was drawn from the Incident-based Reporting System. (See attachment)

Issues for further discussion:

- The 20% of inebriates most frequently using the system are probably familiar to other parts of AHS as well. In using resources more wisely with them, a difference could be made in the system as a whole. How can we accomplish that best?
- Screening standards should be the same state-wide.
- What basic screenings need to be in place for this population?

Minutes
• Would it be possible for ambulances to cover the necessary screenings? Would it allow for a standardization of the tool? What would be the implications? This could be done with the oversight of Emergency department physicians. • Which of these issues might require a change in State Statutes?